

THE GOLDEN AGE OF AGING, AND ITS DISCONTENTS

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Today's senior citizens in the United States live in the "golden age of aging," receiving more benefits from the government than ever before, far beyond what they reasonably could have expected to receive a generation ago. A large portion of government spending goes to seniors, especially to cover medical care, and Professor Schuck argues that much of this spending is inefficient and, at times, ineffective. In light of the 2008–2009 economic climate and President Obama's push for health care reform, Professor Schuck argues that now is the time to make the hard choices that would lead to more efficient medical care for seniors, even though that may mean rationing of care, an intensely controversial proposition. He argues that the decision on whether to go forward with a medical procedure should be based on the number of quality-adjusted life years (QALYs) derived from the procedure, which is often heavily tied to age.

I am particularly gratified to be addressing an aspect of elder law, as it provides me with an opportunity to return to an old scholarly interest. My very first article as a law professor, entitled *The Graying of Civil Rights Law: The Age Discrimination*

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Act of 1975, was published in my vanity press, *The Yale Law Journal*.¹ In the article, I maintained that age is a characteristic whose vulnerability to invidious discrimination is quite unlike—and much less unjust than—that of race, religion, national origin, and other suspect classifications of the kinds of minorities that Title VI of the Civil Rights Act of 1964 was intended to protect. Arguing that modeling the Age Discrimination Act of 1975 (ADA) on Title VI, as Congress had done, was a category mistake, I predicted that its analytical incoherence would produce much litigation. That prediction, like my stock market bets, turned out to be quite wrong. In fact, the ADA has seldom been cited or litigated.² So much for my maiden academic voyage on the perilous seas of prognostication.

For substantive significance (as distinct from theoretical interest), I would have done far better to scrutinize the Age Discrimination in Employment Act of 1967 (ADEA),³ which has been a mother lode for litigators. Indeed, the Supreme Court in June handed down only the most recent of its many decisions interpreting the ADEA.⁴ Yet much the same conceptual and analytical critique I made of the ADA applies as well to the ADEA. I shall return to this question of age discrimination, but it is peripheral to my lecture here.

Instead, my focus is on the policy implications of the impending fiscal crisis in Medicare, which is driven in large part by the aging of America. This aging takes three forms that can usefully be distinguished. The first is *chronological* aging: the population as a whole is getting older. The second is *physical* aging due to disability, illness, and more routine wear-and-tear. While generally correlated with chronological aging, it follows a different path due to improved living standards, health care, and so forth. The third is what David Thomson calls *political* aging: “the shift from youth to elder priorities which has dominated all welfare states in the last few decades.”⁵ Although

1. Peter H. Schuck, *The Graying of Civil Rights Law: The Age Discrimination Act of 1975*, 89 YALE L.J. 27 (1979).

2. JOAN M. KRAUSKOPF ET AL., *ELDERLAW: ADVOCACY FOR THE AGING* § 3.11 (2d ed. 1993). As of August 2008, only eighteen cases had been reported under the Act since July 1979. *Id.*

3. Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621–634.

4. *Gross v. FBL Fin. Servs., Inc.*, 129 S. Ct. 2343 (2009) (increasing the burden on ADEA plaintiffs). Key Democratic lawmakers are seeking to overturn the decision. Steven Greenhouse, *Democrats Working to Overturn Justices on Age Bias*, N.Y. TIMES, Oct. 6, 2009, at A20.

5. DAVID THOMSON, *SELFISH GENERATIONS? HOW WELFARE STATES GROW OLD* 4 (rev. ed. 1996).

the eligibility structure of certain social programs uses chronological aging, it is physical aging that occasions the massive costs that burden some of these programs, particularly Medicare and Medicaid, and it is political aging that requires that we reconsider what our priorities in such programs should be in the future.

Although I shall refer mainly to Medicare, most of the analysis applies with at least as much force to Medicaid, which pays the vast majority of long-term care costs for the elderly (as well as for some of their other health-related costs),⁶ and whose fiscal condition is in some ways even more parlous than that of Medicare.⁷ I do not focus on Social Security, which is also approaching insolvency, because the Medicare/Medicaid crisis is far more severe and immediate and involves much more money.⁸ In addition, the policy reforms needed to make Social Security actuarially and fiscally sustainable, while certainly daunting as a political matter,⁹ are more straightforward than for Medicare and Medicaid.¹⁰ At this writing, the health care reforms recently passed by Congress and signed by President Obama seem likely, despite energetic assurances to the contrary, to increase Medicare costs, not reduce them.¹¹

6. See U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/home/medicaid.asp> (last visited Mar. 14, 2010).

7. See generally MARTHA N. OZAWA & YEONG HUN YEO, PROBLEMS IN MEDICAID FUNDING (2007).

8. SOC. SEC. ADMIN., STATUS OF THE SOCIAL SECURITY AND MEDICARE PROGRAMS: A SUMMARY OF THE 2009 ANNUAL REPORTS, <http://www.ssa.gov/OACT/TRSUM/index.html> ("Medicare's financial difficulties come sooner—and are much more severe—than those confronting Social Security."). The projected Medicare Trust Fund deficit over the next seventy-five years is now estimated at almost \$38 trillion. See OZAWA & YEO, *supra* note 7, at 9.

9. Social Security, famously, "is the *third rail* of American politics. Touch it, you're dead." For the provenance of this metaphor, see William Safire, *Third Rail*, N.Y. TIMES MAG., Feb. 18, 2007, <http://www.nytimes.com/2007/02/18/magazine/18wwwInsafire.t.html>.

10. For analyses of many of the options, see VIRGINIA P. RENO & JONI LAVERY, NAT'L ACAD. OF SOC. INS., FIXING SOCIAL SECURITY: ADEQUATE BENEFITS, ADEQUATE FINANCING (2009), http://www.nasi.org/publications2763/publications_show.htm?doc_id=1067669 and Craig Copeland, *Social Security Reform: How Different Options Might Affect Future Funding*, EMP. BENEFIT RES. INST. NOTES, Sept. 2009.

11. Dennis Smith, *Note to Congress: Expanding Healthcare Entitlements Is Bad Policy*, HERITAGE FOUND. BACKGROUNDER, Feb. 12, 2009, at 5. Experience suggests that massive savings from eliminating "fraud and abuse" will prove illusory.

I shall use the Medicare crisis to explore a number of topics that we must carefully analyze if we are to figure out how to contain it.¹² These topics are (1) “the golden age of aging”; (2) the rapidly approaching twilight of this golden age; (3) the political economy of aging; (4) the need for better targeting in social programs; (5) the hard choices that are upon us; (6) the moral demands of intergenerational relationships; and (7) some policy approaches that flow from my analysis. Along the way, I shall defend some of the hard choices that I favor—a privilege I claim as a senior citizen who would have to bear my share of the constraints that these policy choices would impose on us elderly.

I. The Golden Age of Aging

Today is truly the golden age of aging. Lest we take this for granted, as we do so much of our good fortune, let me illustrate with demographic statistics how much better we seniors live than ever before in our history. (I would say “ever before in *human* history,” except that seniors in some other industrialized countries like Japan live longer, enjoy more respect, and in some ways live better than their American counterparts do.) This dramatic increase in well-being is evident in statistics on life expectancy, quality of life, independent living, family ties, education levels, income and wealth, and safety net benefits.

A. Life Expectancy

The average life span of an American born only a century or so ago was forty-seven years; today it is seventy-eight (and about eighty-three for women).¹³ In the United States, as elsewhere, this gain is mainly due to public health measures and a higher standard of living, although improved health care that dramatically reduced infant and

12. This is hardly an unexplored subject. For very recent book-length discussions, see, for example, ROBERT N. BUTLER, *THE LONGEVITY REVOLUTION* (2008) and JAMES H. SCHULZ & ROBERT H. BINSTOCK, *AGING NATION: THE ECONOMICS AND POLITICS OF GROWING OLDER IN AMERICA* (2006).

13. MELONIE HERON ET AL., CTR. FOR DISEASE CONTROL, NATIONAL VITAL STATISTICS REPORTS 26 tbl.7 (2009), http://www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_14.pdf. For the world as a whole, it was about thirty years; today it is sixty-seven. *A Slow-Burning Fuse*, *ECONOMIST*, June 27, 2009, at 3.

maternal mortality played its part.¹⁴ Comparatively speaking, however, the United States has little to boast about; life expectancy is eighty-three in Japan and exceeds eighty-one in Israel, Austria, Spain, and some other countries.¹⁵

Our vastly longer life span has transformed the very concept of being elderly. We commonly remark on how much younger we look and feel than our parents did at our ages—if they were fortunate enough to have survived this long. Another aspect of this transformation of what it means to be elderly, one more relevant to Social Security than to Medicare, is the number of years spent in retirement after working ceases. Today, it is almost twenty years in the United States (again, higher for women), a bit below the OECD average,¹⁶ reflecting a pattern of earlier retirement coupled with longer life span.

B. Quality of Life

Although the quality of life for the elderly is difficult to define, one important index of it is surely their ability to engage in the activities of everyday life during those years. Recent research finds that disability for seniors in the United States has declined significantly in recent years, as it has in some other (but not all) OECD countries.¹⁷ In this important sense, physical age has not advanced nearly as steadily and remorselessly as chronological age. Seniors also have much less to fear about their personal security because of steadily declining rates of violent crime, of which they were especially vulnerable victims in the past.¹⁸

14. RICHARD J. ZECKHAUSER ET AL., *HEALTH INTERVENTION AND POPULATION HETEROGENEITY* 25–29 (1985).

15. ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *SOCIETY AT A GLANCE*, OECD SOCIAL INDICATORS 117 tbl.HE8.4 (2009), http://www.oecd.org/document/24/0,3343,en_2649_34637_2671576_1_1_1_100.html.

16. ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT, *STATISTICAL PORTAL*, http://www.oecd.org/topicstatsportal/0,3398,en_2825_494553_1_1_1_1_1,00.html (follow “OECD Population Pyramids in 2000 and 2050”).

17. Kenneth G. Manton et al., *Long-Term Trends in Life Expectancy and Active Life Expectancy in the United States*, 32 *POPULATION & DEV. REV.* 81, 83 (2006).

18. In 1973, 9.1 individuals per 1,000 individuals aged over 65 were the victims of a violent crime (homicide, rape, robbery, aggravated assault, and assault). By 2005, only 2.4 individuals per 1,000 individuals over the age of 65 were the victims of violent crime. BUREAU OF JUSTICE STATISTICS, *HOMICIDE TRENDS IN THE U.S.*, <http://www.ojp.usdoj.gov/content/homicide/tables/elder> (last visited Feb. 8, 2010).

C. Independent Living

Another measure of the quality of life, at least in American culture, is independence. In the United States, in 2008, 80.1% of people aged sixty-five and over owned their house, most of them free and clear of mortgage.¹⁹

D. Family Ties

If this independence were achieved at the cost of close family ties, it might not be an unequivocally good thing, but this does not appear to be the case for today's seniors. Sixty-six percent of them live within thirty minutes of a family member.²⁰ In addition, of course, longer life spans mean that they have more years living with their spouses.²¹

E. Education Level

Another aspect of quality of life is education, which enhances one's ability to enjoy the cultural riches that an increasingly integrated world offers, an ability that has been vastly extended by cable TV and the Internet. Every generation of seniors has been better educated than the last. A generation ago, 24% of the elderly were high school

19. U.S. CENSUS BUREAU, HOUSING VACANCIES AND HOME OWNERSHIP tbl.957, <http://www.census.gov/compendia/statab/2010/tables/10s0957.pdf>. In 2007, roughly 68% of homeowners aged sixty-five and older owned their homes free and clear. U.S. Dep't of Health & Human Servs., A Profile of Older Americans: 2009, http://www.aoa.gov/AoARoot/Aging_Statistics/Profile/2009/11.aspx (last visited Mar. 14, 2010). Their ability to raise the cash necessary to live independently may also be growing as they sell their "life settlement" insurance policies to businesses that can then securitize the policies. See, e.g., Jenny Anderson, *Wall Street Pursues Profit in Bundles of Life Insurance*, N.Y. TIMES, Sept. 5, 2009, at A1. This practice may be restricted in the future. E-mail from John H. Langbein, Sterling Professor of Law, Yale Law Sch., to author (Oct. 4, 2009) (on file with author).

20. GEORGE P. MOSCHIS, *MARKETING TO OLDER CONSUMERS: A HANDBOOK OF INFORMATION FOR STRATEGY DEVELOPMENT* 63 (1992).

21. As of 2007, 78% of men and 57% of women aged sixty-five to seventy-four were married. FED. INTERAGENCY FORUM ON AGING-RELATED STATISTICS, *OLDER AMERICANS 2008: KEY INDICATORS OF WELL-BEING* 5 (2008), http://www.agingstats.gov/agingstatsdotnet/Main_Site/Data/2008_Documents/OA_2008.pdf [hereinafter FED. INTERAGENCY FORUM]. At older ages, the percentages of married individuals obviously decreases. *Id.* In 2007, 38% of women aged seventy-five to eighty-four and 15% of women eighty-five and over were married; 74% of men seventy-five to eighty-four and 60% of men aged eighty-five and older were married. *Id.*

graduates, and only 5% held a bachelor's degree.²² In 2007, 76% of them had graduated from high school, and 19% held at least a bachelor's degree.²³ Additionally, the gender gap in educational attainment continues to narrow.²⁴

F. Income and Wealth

Over the past forty years, American males aged fifty-five and over have become substantially more likely to retire. In 1963, 90% of men aged fifty-five to sixty-one were active in the workforce.²⁵ By 2006, only 75% of men in that age group were in the workforce—a huge decline.²⁶ In 1963, 76% of men aged sixty-two to sixty-four were employed; as of 2006, the comparable figure was only 52%.²⁷ Female employment trends go in the other direction. Because of relatively low female paid employment in the 1960s, women over fifty-five are now *more* likely to be working than before.²⁸

Significantly, the long-range trend toward earlier retirement for seniors has reversed in the last twenty-five years.²⁹ In March 2009, 33% of men and 25% of women aged sixty-five to sixty-nine were employed, and although the proportion of older Americans who work declines sharply after age sixty-five, 14% of men and 8% of women who were seventy or older were still working.³⁰ People aged fifty-five and older accounted for two-thirds of the net jobs created during the employment expansion between late 2001 and late 2007. Perhaps most remarkable, they have actually gained nearly one million jobs during this recession at a time when labor participation has fallen for

22. *Id.* at 6.

23. *Id.*

24. *Id.*

25. *Id.* at 18.

26. *Id.* at 88.

27. *Id.*

28. *Id.*

29. See *Why Are Americans Delaying Retirement Date?*, Employee Benefit Research Institute, Fast Facts #138, Oct. 1, 2009, available at <http://www.ebri.org/pdf/FFE138.01Oct09.Finl.pdf>. For an analysis of this change, see JOHN H. LANGBEIN ET AL., *PENSION AND EMPLOYEE BENEFIT LAW* 847–49 (4th ed. 2006). At the same time, the share of people taking early Social Security benefits rose sharply in fiscal year 2009, which may reflect recession-related employment obstacles. Richard Wolf, *Social Security Collectors Up 19%*, USA TODAY, Oct. 2, 2009, at A1. It is unclear how these developments square with those discussed in *supra* text accompanying notes 23–25.

30. PATRICK PURCELL, CONGRESSIONAL RES. SERV., *INCOME AND POVERTY AMONG OLDER AMERICANS IN 2008*, at 22 (2009).

every other age group.³¹ Indeed, during the 2000–2008 period when the teenage employment rate dropped by 34%, the rate for those aged fifty-five to sixty-four rose by 7%, and the rate for seniors increased by 29%.³²

Internationally, America's seniors may be unique in this respect: in 2008, almost a third of those aged sixty-five to sixty-nine were still in the labor force, compared with only 4% in France either working or looking for work.³³ All of this suggests that current and soon-to-be seniors, far from being shunted aside by employers in favor of younger workers, are actually favored by them, which in turn implies that age discrimination may now be working in reverse!

In sharp contrast with earlier generations, the incomes of today's seniors exceed those of the average American. Fifty years ago, 35% of older Americans lived in poverty; in 2008, less than 10% of them did.³⁴ In 1974, only 18% of older Americans were categorized as high-income; in 2006, nearly 29% of them were.³⁵ Their Social Security benefits are not only larger, but they are indexed to inflation, an advantage granted by few, if any, private pensions³⁶ and only a handful of public programs.³⁷ In fact, leading economists believe that these indexed benefits actually overcompensate recipients for inflation.³⁸ Most seniors' Medicare Part B benefits for physician services are also protected against inflation because their premiums cannot be increased for any year (such as 2009) in which their Social Security benefits do not rise.³⁹ And although seniors spend more than younger

31. *Employment Data Are Showing Shades of Gray*, WALL ST. J., Aug. 19, 2009, at C14.

32. *Left Behind*, ECONOMIST, Aug. 22, 2009, at 26–27.

33. Catherine Rampell & Matthew Saltmarsh, *A Reluctance to Retire Means Fewer Openings*, N.Y. TIMES, Sept. 3, 2009, at A1.

34. PURCELL, *supra* note 30, at 24.

35. FED. INTERAGENCY FORUM, *supra* note 21, at 12.

36. Richard L. Kaplan, *Top Ten Myths of Social Security*, 3 ELDER L.J. 191, 207 (1995).

37. E-mails from David A. Super, Professor of Law, Univ. of Md. Law Sch., to author (Aug. 13, 2009) (on file with author). Indeed, Social Security's indexing method has given each senior a bonus-over-inflation of \$516 this year, while a special "hold harmless" provision in the Medicare Part B program has given those seniors an additional \$96, for a total of \$612. See *The Diet COLA Myth*, WALL ST. J., Aug. 28, 2009, at A14.

38. See, e.g., Michael J. Boskin, *Causes and Consequences of Bias in the Consumer Price Index as a Measure of the Cost of Living*, 33 ATLANTIC ECON. J. 1, 3 (2005).

39. Robert Pear, *Social Security Benefits Not Expected to Rise in '10*, N.Y. TIMES, May 3, 2009, at A23.

Americans on health care, whose cost increases exceed inflation, overall they are not affected any worse by inflation.⁴⁰

In addition to their income advantage, seniors enjoy a wealth advantage. A study published in 2000 indicated that 18% of them had a net worth between \$200,000 and \$500,000; another 20% had a net worth between \$100,000 and \$200,000.⁴¹ This substantial net worth increased significantly during the large rise in housing equity value that ended in 2006–07. On the other hand, some portion of this increase was erased by the subsequent housing bust,⁴² and the debt burdens carried by the elderly have increased.⁴³ In any event, recent polling evidence suggests that seniors are weathering the recession better than other Americans.⁴⁴

G. Safety Net

The safety net protects seniors much more than any other group. It protects them against the risk of indigence through entitlement programs, especially Social Security and Supplemental Security Income (SSI) for income maintenance, Medicare for health care and (since 2006) for prescription drugs, Medicaid for long-term care and other services, and Food Stamps. Other programs such as Meals on Wheels and social services, while not entitlements, are available to more seniors than ever before.⁴⁵ Although future redesigns and cuts in these

40. Andrew G. Biggs, *How Different Is Grandma's Spending?*, AMERICAN, Oct. 17, 2009, <http://www.american.com/archive/2009/october/how-different-is-grandmas-spending>.

41. ROBERT SCHAFER, JOINT CTR. FOR HOUSING STUDIES OF HARVARD UNIV., HOUSING AMERICA'S SENIORS 7 (2000). Nearly 20% of seniors, however, had a net worth of less than \$25,000. *Id.* at 3.

42. See Desmond Lachman, *A Return to Saving?*, AM. ENTERPRISE INST. PUB. POL'Y RES., July 2009, <http://www.aei.org/article/100754> (discussing how the Federal Reserve estimates that since early 2008, household wealth for the entire U.S. population has declined by \$13B; there is no breakdown for seniors). Home prices are now rising again in many communities. Deborah Charles, *White House Says U.S. Housing Market Bottoming Out*, REUTERS, Aug. 21, 2009, available at <http://www.reuters.com/article/idU5TRE57K3BE20090821>.

43. Craig Copeland, *Debt of the Elderly and Near Elderly, 1992–2007*, EMP. BENEFIT RES. INST. NOTES, Oct. 2009, at 2, available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_10-Oct09.DebtEldly.pdf.

44. Karlyn Bowman, *The Recession and Retirees*, FORBES, Oct. 19, 2009, available at <http://www.aei.org/article/101183>.

45. See MEALS ON WHEELS FOUND., *Food for Thought*, Fall 2009, at 2, <http://www.mowf.net/site/files/797/86465/311510/426965/FallNewsletter-fy10.pdf>; Meals-on-Wheels Greater San Diego, Inc., <http://www.meals-on-wheels.org/aboutus/index.php> (last visited Mar. 14, 2010).

programs are likely, benefits for the elderly are often the last to be cut both because no one expects them to work and because, as explained in my discussion of the political economy of aging, their political potency exceeds that of any other demographic group.

This demographic and survey data establish that the elderly in America are well-off by whatever measures one employs. This is true subjectively,⁴⁶ objectively, in terms of absolute levels of well-being, and in comparative terms, whether the comparison is to past generations of elderly, to the average non-elderly American today, or to the elderly in almost all other wealthy democracies.

All things considered, today's seniors are probably the best-off generation of seniors who ever lived. This distinction will continue for the near future and, because any changes are likely to be phased in over time, perhaps until their deaths. It informs my later analyses of the political economy of aging in Part III and of intergenerational equity in Part VI.

II. The Twilight of the Golden Age?

Like all golden ages, this one too will come to an end, at least fiscally. This is true even though (indeed, as a fiscal matter, *because*) life spans will, barring some ecological or other catastrophe, continue to lengthen, better technologies of prevention and cure will continue to develop, and seniors' health status will continue to improve.

My reasoning goes like this: In due course, the United States will resume a trajectory of real economic growth. All Americans, including pensioners, will share in the benefits of this growth, although not equally. Nevertheless, the so-called dependency ratio⁴⁷—the ratio of seniors and dependent children who are not self-supporting to the working-age population whose earnings and taxes must pay for most of their support—will continue to rise. Although the dependency ratio is actually much lower today (.66) than it was at its height in 1965

46. In 2009, 76% of Americans aged sixty-five to seventy-four reported that they were "very happy" or "pretty happy." Only 19% of Americans in that age range reported that they were "not too happy." SOC. & DEMOGRAPHIC TRENDS PROJECT, PEW RESEARCH CTR., GROWING OLD IN AMERICA: EXPECTATIONS VS. REALITY 54 (2009).

47. On the dependency ratio, see LAURENCE J. KOTLIKOFF & SCOTT BURNS, THE COMING GENERATIONAL STORM: WHAT YOU NEED TO KNOW ABOUT AMERICA'S ECONOMIC FUTURE 6-9 (2004).

(.94) and will remain much lower for many decades,⁴⁸ its political and fiscal significance depend less on the dependent group's size than on its *composition* as between children and elderly. In 1965, the elderly constituted less than 20% of the dependent cohort; today, they are about 30%.⁴⁹ Because children are supported almost entirely by families in private budgets while retirees are supported largely by taxpayers through redistributive programs⁵⁰ in fiercely contested public budgets, provision for seniors is more of a political issue.⁵¹

Although the dependency ratio is not particularly high compared with recent decades, it will soon rise due to the combination of Baby Boomer retirements and a workers cohort diminished by the Baby Bust that followed the post-war Boom. Thus, meaningful reform of Medicare, Medicaid, Social Security, and other public pension systems⁵² cannot be delayed much longer, particularly because a long phase-in period for any significant changes, especially in pensions, is required for both fairness and political reasons. Indeed, a long phase-in period, however necessary, ceases to be possible at some point.⁵³ Absent fundamental and immediate changes in Medicare's fiscal and benefit structure, the Medicare Trust Fund will be exhausted in 2019, two years earlier than the Trustees projected as recently as a year ago.⁵⁴ And even these dire estimates do not take full account of the

48. LAURA B. SHRESTHA, CONG. RESEARCH SERV., AGE DEPENDENCY RATIOS AND SOCIAL SECURITY SOLVENCY app. fig.1 (2006), <http://aging.senate.gov/crs/ss4.pdf>.

49. *Id.*

50. Programs for seniors tend to be redistributive in at least two senses: favoring retirees over working taxpayers and favoring low-income seniors over wealthier seniors.

51. I thank Jerry Mashaw for bringing this important point to my attention.

52. See, e.g., Danny Hakim, *Pension Costs for Local Governments May Triple by 2015, Analysis Says*, N.Y. TIMES, July 7, 2009, at A19.

53. As one observer put it, "[t]he transfer arrangement between cohorts and age-groups in the United States apparently is and may well continue to be out of phase with demographic and economic development, to an extent that may be impossible to correct." Peter Laslett, *Is There a Generational Contract?*, in JUSTICE BETWEEN AGE GROUPS AND GENERATIONS 35 (Peter Laslett & James S. Fishkin eds., 1992).

54. SOC. SEC. ADMIN., *supra* note 8. On the Social Security side, the combined OASDI Trust Fund will likely be exhausted in 2037, with the disability insurance fund exhausted in 2020. *Id.* I am not suggesting, of course, that the Trust Fund marks the limit of the government's fiscal commitment to pay Medicare's costs. Officials know, and the public presumably assumes, that the government's general revenues also stand behind the program. See, e.g., ERIC M. PATASHNIK, PUTTING TRUST IN THE U.S. BUDGET: FEDERAL TRUST FUNDS AND THE POLITICS OF COMMITMENT (2000).

immense deficits that the Congressional Budget Office now projects for at least a decade in light of the reduced revenues induced by the current recession, the unprecedented fiscal and debt commitments already approved by Congress,⁵⁵ and the further deficit increases likely entailed by health insurance reform legislation.⁵⁶

Precisely when (or to some optimists, whether) the day of reckoning will actually occur depends on many political, demographic, technological, actuarial, economic, and other factors, some of which are discussed below. It could be deferred somewhat under certain conditions: higher fertility rates, higher rates of productivity growth, more immigration by young workers, or later retirements. Looking to these possibilities to rescue health and pension programs, however, would be very risky.

A. Fertility

Fertility rates are unlikely to be high enough to avert this outcome,⁵⁷ and in any event would take too long to increase the size of the work force to “rescue” fiscally the Boomer generation that is about to begin retiring. Indeed, during the two decades required for the newborns to enter the work force, they would serve only to *increase* the dependency ratio.

B. Productivity Growth

Except for a burst of productivity growth during the late 1990s, probably related to computerization, the rise since the 1960s has been relatively modest, and any future growth-enhancing factors will be limited by the steady aging of the population, which tends to be a

55. CONG. BUDGET OFFICE, THE BUDGET AND ECONOMIC OUTLOOK: AN UPDATE 1 (2009), http://cbo.gov/ftpdocs/105xx/doc10521/2009BudgetUpdate_Summary.pdf.

56. Despite President Obama’s assurance that it will be deficit-neutral now and in the future, I view this as inconceivable due to, among other things, its reliance on Medicare cuts and fraud-and-abuse savings that are very unlikely to be realized.

57. A rise in U.S. fertility rates is possible. See *The Best of All Possible Worlds?*, *ECONOMIST*, Aug. 8, 2009, at 68 (reporting that contrary to customary demographic patterns, a rising human development index, at some point, is correlated with, and may cause, increases in fertility). Immigration is fueling small baby booms in the United Kingdom, France, and some other European countries. *Id.*

drag on productivity growth.⁵⁸ Yet only that level of growth seen in the 1990s could possibly produce the kind of durable expansion in wealth that could render Medicare and Social Security fiscally sustainable in anything like their present forms.⁵⁹ Such growth seems highly unlikely.

C. Immigration

Although young immigrants (especially those who will leave before they draw program benefits) and later retirements would help to lower the dependency ratio, they cannot solve the imminent fiscal crisis in Medicare. Young, highly skilled immigrants could increase productivity and fertility rates, while unskilled immigrants, particularly the undocumented, contribute to the trust funds yet seldom receive program benefits. In order to make a substantial difference, however, more immigrants would have to be admitted than Congress is likely to allow.⁶⁰

D. Delayed Retirement

American workers have indeed been delaying retirement,⁶¹ even before the recent shrinkage in home equity and retirement savings

58. On the other hand, the increased hiring of workers aged fifty-five and over may suggest that employers disagree. See *supra* note 31 and accompanying text. A spurt in labor productivity during the second quarter of 2009 may or may not be an augury of higher rates to come. BUREAU OF LABOR STATISTICS, PRODUCTIVITY AND COSTS, FOURTH QUARTER AND ANNUAL AVERAGES 2009, REVISED tbl.B (2009), <http://www.bls.gov/news.release/prod2.nr0.htm>.

59. For a more optimistic view, see Lawrence H. Thompson, *Sharing the Pain of Social Security and Medicare Reform*, RETIREMENT PROJECT (Urban Inst., Washington, D.C.), Aug. 2000, available at <http://www.urban.org/publications/309607.html>. I am grateful to Jerry Mashaw for bringing this work to my attention.

60. Immigration to the United States is already at or above historic levels in absolute terms and near historic levels as a percentage of the population. It will not solve our fiscal problems. See, e.g., Steven A. Camarota, *Immigration in an Aging Society: Workers, Birth Rates, and Social Security* (Ctr. for Immigration Studies, Washington, D.C.), Apr. 2005, at 15; Dowell Myers, *Aging Baby Boomers and the Effect of Immigration: Rediscovering the Intergenerational Social Contract*, GENERATIONS, Winter 2008–2009, at 18, 22.

61. Murray Gendell, *Older Workers: Increasing Their Labor Force Participation and Hours of Work*, MONTHLY LAB. REV., Jan. 2008, at 41, 41. From 1950 to 1955, the average age of men exiting the labor force was 66.9 years; women exiting the workforce during that period averaged 67.6 years. Retirement ages dropped steadily throughout subsequent decades. From 2000 to 2005, the average age for men exiting the labor force was 61.6 years; the comparable figure for women was 60.5 years of age. *Id.* at 42 tbl.1.

and the shift from defined benefit to defined contribution pensions.⁶² Recent evidence suggests that this trend is good economic policy, actually improving the employment prospects of younger workers.⁶³ Whether the trend of delaying retirement will continue, however, remains to be seen. After all, until recently the trend went in the opposite direction, and much depends on the changing nature of jobs and composition of the workforce.

Social policy experts have debated for decades the merits of various policy responses to the insecure financing of these programs for the elderly. Fiscal projections and policy analyses are regularly churned out by the Social Security and Medicare Trust Funds, the Office of Management and Budget, the Congressional Budget Office, and think tanks like Brookings and the American Enterprise Institute. They attribute Medicare's looming insolvency to the physical aging⁶⁴ of the population, technological advances that are often both costly and beneficial, excessive testing and treatment, sluggish economic growth, policy changes that promised higher benefits without securing the revenues to pay for them, unrealistic public expectations created by dissembling politicians, and especially health care cost inflation.⁶⁵ The analyses identify promising policy fixes, but no quick or easy solutions—particularly given the lack of political consensus on whether and to what extent future pensions, which are to some degree substitutes for publicly financed health care programs, should be the responsibility of the state or of individuals. The struggle for problem definitions and policy solutions will be shaped largely by the political economy of aging.

62. See *supra* notes 29–32 and accompanying text.

63. See Jonathan Gruber et al., *Social Security Programs and Retirement Around the World: The Relationship to Youth Employment* 52–58 (Nat'l Bureau of Econ. Research, Working Paper No. 14647, 2009).

64. It is physical aging, not chronological aging per se, that generates these costs. We could reduce the program costs associated with chronological aging by raising the age at which people become eligible for benefits, but the costs associated with physical aging—illness and disability—are far harder for society to postpone.

65. CONG. BUDGET OFFICE, *THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING* (2007), <http://www.cbo.gov/ftpdocs/87xx/doc8758/Intro.shtml>. Indeed, then-CBO director Peter Orzag argued in 2007 that the effect on Medicare and Medicaid of the aging of the population is swamped by health care inflation. *Id.*

III. Political Economy of Aging

No large demographic group in American life defends and advances its interests in the political sphere more effectively than the elderly. They constitute a formidable and ardently sought-after voting bloc, given their comparatively high propensity to register and vote in elections.⁶⁶ They are broadly distributed across all states and communities, while also concentrated in some important swing states, especially Florida. Seniors are also well-organized through the AARP, one of the country's most effective lobbies, and through other senior organizations.⁶⁷ Unlike many other groups that must forge a common identity and sense of solidarity, the elderly share a truly natural commonality of experience—aging—which creates an automatic community of interest in many areas such as health care and pension policy, and this enables them to focus their political efforts as few groups can. Their focus and allegiance are intensified and unified, moreover, by the fact that they cannot leave the group—unlike, say, the poor.⁶⁸

Finally, the elderly enjoy a unique relationship with the rest of society, one characterized by immense sympathy, respect, and even self-projection by younger people. Taxpayers view seniors, more than other groups of social program beneficiaries, as “good apples” (a term whose meaning in this context I discuss in Part IV). This view reflects not only the special emotional factors just discussed but, presumably, also the expectation that giving benefits to retirees will not create the moral hazard and other perverse incentives that giving such benefits to those of working age might produce.

66. For example, 68.1% of individuals registered to vote aged fifty-five to sixty-four voted in the 2008 presidential election; by contrast, less than half of potential voters aged eighteen to thirty-four voted. See U.S. CENSUS BUREAU, VOTING AND REGISTRATION IN THE ELECTION OF NOVEMBER 2008, tbl.4c, <http://www.census.gov/population/www/socdemo/voting/cps2008.html>.

67. Membership in AARP, which until 1999 was known as the American Association of Retired Persons, is not limited to seniors or retirees but extends to all who are fifty or older. For an account of AARP's political effectiveness in connection with the amendment of the ADEA, see Samuel Issacharoff & Erica Worth Harris, *Is Age Discrimination Really Age Discrimination?: The ADEA's Unnatural Solution*, 72 N.Y.U. L. REV. 780, 810–19 (1997). For an analysis of AARP's position on the current proposals for Medicare reform, see Scott Harrington, *The AARP Paradox*, AMERICAN, Oct. 2, 2009 (speculating about why AARP seems willing to countenance Medicare cuts to achieve universal coverage).

68. I am indebted to David Super for this point. He notes that members of some minority groups can leave by “passing” into other groups, and the young will leave by aging into other groups.

To be sure, the elderly face their own special disadvantages, and their relationship with the young is complicated by Americans' obsession with youthful vigor and fear of growing old (a fear that we probably share with members of all other modern societies).⁶⁹ But although these fears surely contribute to some negative stereotypes of the elderly (including much popular humor), the elderly enjoy an enormous compensating advantage not possessed by other minority groups: they are perceived as "us" as our future selves rather than as alien or "other" or "they." It is for this reason that, as I observed earlier, the elderly as a group are not vulnerable to the same kind of invidious discrimination that severely disadvantages so-called "discrete and insular minorities" and that requires heightened protection of such minorities as a constitutional matter.⁷⁰

These political advantages constitute a double-edged sword. They assure that the common interests of the elderly as a group will always be front-and-center in the calculations of all politicians and that where those interests are unambiguous and unidirectional, they will be well-protected in public policies. This senior power has been exerted at all levels of government in recent decades and can only increase as the population continues to age. At the same time, however, this steadily growing political ascendancy of the elderly threatens to entrench the policy status quo further, as seniors' percentage of the voting population increases and as they resist any proposals for change that might threaten their enviable position.⁷¹ They may resist reform even when certain changes, such as means-testing benefits or increasing the eligibility age, are necessary to make these senior-subsidizing programs affordable in the long run.⁷² Today, for exam-

69. One researcher finds that young adults with negative stereotypes of the elderly are at greater risk of cardiovascular problems. Emma Anthes, *Your Heart is Only as Old as You Feel*, YALE ALUMNI MAG., May/June 2009, at 31, 31. Perhaps the researcher, Becca Levy, has come upon a novel way to improve health status!

70. For development of this idea, see Schuck, *supra* note 1, at 33, 37–38; Issacharoff & Harris, *supra* note 67, at 836–37 ("[T]he antidiscrimination model was captured for the benefit of a group that is not socially reviled, not penurious, neither discrete nor insular, not cut off from the mainstream of society, and not marked by the unmistakable badge of social opprobrium."). Supreme Court doctrine reflects this assessment. See *generally* Mass. Bd. of Ret. v. Murgia, 427 U.S. 307 (1976) (ruling that age is not a suspect classification).

71. *But see* Harrington, *supra* note 67 (speculating about reasons why AARP might countenance Medicare cuts to achieve universal coverage).

72. See, e.g., Susan Page, *Poll: Americans Divided on Health Care Overhaul*, USA TODAY, Aug. 10, 2009, at A1 ("Seniors are by far the most resistant to the idea of changing the current system . . ."); Katharine Q. Seelye, *GENERATION GAP: Age*

ple, a growing plurality of seniors seem to believe, rightly or wrongly, that President Obama's health care reform proposals will hurt them.⁷³ Yet under health insurance reforms recently passed by Congress that will combine guaranteed issue, community rating, and individual insurance mandates, it seems likely that younger, healthier, lower-income workers will be subsidizing older, sicker, higher-income workers through the resulting premium structure.⁷⁴

This political entrenchment and inertia are even more pronounced today because *both* political parties, desperate for senior votes, are competing to be perceived as the most stalwart and unequivocal defenders of the current Medicare program. This is hardly new for Democrats, but it is novel for Republicans who historically have criticized Medicare as wasteful, overcentralized, and overregulated. Now, however, the Republicans are proclaiming that Medicare protects "Grandma" against the euthanasia and harsh cost-cutting that they think "Obamacare" will inevitably entail.⁷⁵ Given the convergence of these Democratic and Republican tides, it is hard to see who will resist efforts by the elderly to use their power to corral ever more resources for themselves and preserve the status quo. Ironically, this is true even where those resources are desperately needed to protect the needs of *future cohorts of seniors*—to say nothing of the needs of other groups, especially children.

This point was put more baldly and provocatively by former Colorado governor Richard Lamm: "[m]y aging body can prevent your kids from going to college. . . . We as a society spend more money turning 80 year olds into 90 year olds than we do 6 year olds into educated 16 year olds."⁷⁶ These are fighting words that raise a profound set of issues. These issues, less belligerently put, are usually analyzed

Divide on Health Care, N.Y. TIMES, Aug. 18, 2009, at A14 ("[A] Gallup poll . . . indicated fewer than half of the Medicare-age people favored changing the system . . .").

73. *Lexington: The Politics of Death*, ECONOMIST, Sept. 5, 2009, at 41.

74. See Michael O. Leavitt et al., *Health 'Reform' Is Income Redistribution*, WALL ST. J., Sept. 28, 2009, at A21.

75. For a discussion of this political strategy, see Ross Douthat, *Telling Grandma 'No'*, N.Y. TIMES, Aug. 17, 2009, at A19. For a critique of House members who claim that the Democratic proposals will hasten the death of the elderly, see Norman Ornstein, *House Leaders Have a Fiduciary Duty to Protect the Institution*, ROLL CALL, Oct. 7, 2009, and Scott Gottlieb & Elizabeth DuPre, *The Living Truth About "Death Panels"*, AEI HEALTH POLICY OUTLOOK Oct. 2009 (criticizing such misleading language but also criticizing proposals' specific provisions on end-of-life counseling).

76. Issacharoff & Harris, *supra* note 67, at 836 n.254.

in the technocratic terms of cost-effectiveness (discussed in Parts IV and V) and the normative terms of intergenerational equity (discussed in Part VI).

IV. Targeting Social Program Resources⁷⁷

One public value that has (or should have) a direct bearing on social policy in general, and on social policy toward the elderly in particular, is what economists call target efficiency. This is the common-sense goal of directing resources to the individuals for whom and the purposes for which they will do the most good. In this view, policy-makers should improve the targeting of social programs so that the programs can accomplish more of their goals while using the same resources to assist the same needy populations for which the programs were (or should have been) primarily designed.

A. The Ubiquity of Poor Targeting

One cannot seriously disagree with the desirability of target efficiency. Instead, the controversy arises over which outcomes constitute the good and which programs contribute the most to it. To be sure, the politicians and bureaucrats who design these programs may reasonably differ on the answers to those two questions. But even so, many social programs are not nearly as well-targeted as they could be; indeed, a few are so poorly targeted as to call their social value into serious question.⁷⁸ President Obama's proposal to give \$250 to all Social Security recipients⁷⁹ is a classic example of such poor targeting.

Some of the reasons for poor targeting are conceptual or analytical, but many of them are purely political. Simply put, groups that receive fewer resources than they want from a program will lobby (and perhaps even sue) for more, and they will be joined in this rent-seeking by others who wish to sell them services.⁸⁰ Conservatives are

77. The discussion in this and the next section draws heavily on PETER H. SCHUCK & RICHARD J. ZECKHAUSER, *TARGETING IN SOCIAL PROGRAMS: AVOIDING BAD BETS, REMOVING BAD APPLES* 46–74 (2006). The interested reader will find more detail there, as well as support for statements made but not footnoted here.

78. For examples, see *id.* at 27–45.

79. Jackie Calmes, *Obama Seeks \$250 Check for Retirees and Veterans*, N.Y. TIMES, Oct. 15, 2009, at B7. The check would also go to veterans and the disabled. *Id.*

80. Also inevitable is the politicization of efforts to assign values to statistical life (VSL) necessary to support the targeting analysis. See, e.g., W. Kip Viscusi, *The*

likely to be skeptical of any effort to improve targeting that they fear may be costly, and they may also fear that such reforms will only serve to legitimate the welfare state and increase its funding. Liberals, for their part, seldom actively champion target efficiency, fearing that acknowledging the problem of poor targeting will play into conservatives' hands and that better-targeted programs will deprive many worthy people of benefits.⁸¹

These political obstacles to better targeting can be overcome. For example, state and congressional reforms in the 1990s to improve targeting in welfare programs resulted in far more money being spent per capita on what most Americans consider the "deserving poor" than was spent before the reforms.⁸² Since then, moreover, politicians' attacks on these newer, better-targeted welfare programs have been much reduced.

B. A Taxonomy and Technology of Targeting

In a recent book,⁸³ economist Richard Zeckhauser and I analyzed the problem of poor targeting in social programs by distinguishing three categories of people. We call them bad draws, bad bets, and bad apples. Only bad draws and bad bets are relevant to my analysis here, which focuses on programs benefitting the elderly. And when I speak of good or bad bets (or draws), the judgment is not absolute but only relative to other people who might claim the same resources. Indeed, they are arrayed along a continuum with no clear dividing line, so that program officials will often have difficulty deciding whether or not to give, say, a costly medical procedure to an elderly person in a certain condition.

"Bad draws are people who were dealt a bad hand at birth or later and who have suffered misfortune as a result," leaving them disadvantaged.⁸⁴ Although many social programs target bad draws, some in fact benefit good draws, like corporate farmers and well-heeled public pensioners.⁸⁵ Bad bets "are people who are unlikely to

Devaluation of Life 18–24 (Vanderbilt Univ. Law Sch. working paper No. 09-14, 2009) (describing strong public opposition to two reductions in VSL by EPA).

81. See David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PENN. L. REV. 541, 593–601 (2008).

82. *Id.* at 586–93.

83. SCHUCK & ZECKHAUSER, *supra* note 77, at 7–27.

84. *Id.* at 7.

85. *Id.* at 38.

derive much benefit from a programmatic intervention on their behalf relative to either the resources that they would consume or the benefits that people who are *better* bets would derive from the same resources.”⁸⁶ A common example of a bad bet who would gain too little benefit compared with what another beneficiary would gain is a person in precarious health competing for a cadaver kidney with a far healthier person. The current priority system for kidney transfers in the United States, holding quality-of-match constant, allocates them first to those who have been waiting the longest and who are often the sickest. However, these are the people who will receive the least benefit from them in terms of “quality-adjusted life years” (QALYs), a conventional, though controversial, policy analytic measure of social benefit in which one QALY means one year of full function, zero QALYs means a year not alive, and a fractional QALY means an in-between state such as a year involving some pain or disability.⁸⁷

The more common kind of bad bet, however, is an individual who will derive too little benefit relative to the material resources he or she consumes. An elderly person in poor condition is a low-value candidate for an expensive heart valve transplant even though heart valves, while costly, are readily available. A college student who is likely to drop out is a bad bet for heavily subsidized higher education. One who has already dropped out of high school is an even worse bet, yet, remarkably, public colleges are increasingly placing it.⁸⁸

Any particular application of the bad bet concept in the name of target efficiency requires society to make highly controversial moral judgments and to analyze social costs and benefits, which in turn necessitates empirical determinations that for familiar reasons may be elusive and will surely be politicized, as in the case of organ allocation. Such decisions can be highly contestable—and properly so. One common basis for contestation is the value of fairness. Properly understood, however, target efficiency is complementary to fairness, not contradictory to it. Allocating scarce resources to bad bets rather than to good ones is wasteful and surely unfair, even when the bad bets are admirable people, as in the case of spending hundreds of thousands of

86. *Id.* at 7–8.

87. *Id.* at 50. The QALY measure is explained and its use defended. *Id.* at 50–55.

88. See *id.* at 138 n.3 (citing Karen W. Arenson, *Can't Complete High School? Go Right to College*, N.Y. TIMES, May 30, 2006, at A1).

dollars on an exemplary citizen who is near death.⁸⁹ Those resources could accomplish much more for other medically needy citizens, promoting both fairness and cost-effectiveness goals.

In a world of limited resources, the importance of target efficiency lends urgency to the inevitable need to prioritize among social welfare expenditures, most obviously in programs subsidizing medical care. The word “prioritizing” is often a euphemism for the dreaded word “rationing.” In conventional political discourse—most notably in the current health care debate—the term rationing is used only to cast a proposal into outer darkness; it is never used to describe and justify an allocation technique that is necessary, albeit regrettable. If using the prioritizing euphemism helps to render the reality and necessity of rationing more acceptable to the public while not obscuring what is actually at stake in the policy, there may be no harm in it. With apologies to La Rochefoucauld, one might say that such a euphemism is the homage that politicians pay to unpleasant policy imperatives that compromise our abstract moral ideals.⁹⁰ Viewed most charitably, we use it to make our tragic choices more palatable.⁹¹ More realistically, it serves to conceal sloppy thinking and mask political cowardice. Target efficiency and better bets are the unacknowledged victims of these poor choices.

Rationing of scarce resources, then, is an inescapable feature of all rational choice—although it matters a great deal precisely which constraints such choice is under and whether the rationing is done by bureaucratic fiat, market decisions, or some hybrid process. More to my present point, the necessity for rationing in the design of public programs is increasingly obvious and undeniable for fiscal, demographic, technological, and other reasons.⁹² Both Medicare and managed care organizations routinely discourage expensive procedures

89. See Lawrence K. Altman, *The Man on the Table Devised the Surgery*, N.Y. TIMES, Dec. 25, 2006, at A1. Famously, the eminent surgeon Dr. Michael DeBakey received extensive heart repair, at a cost exceeding \$1 million, when he was ninety-seven. The hospital apparently did not charge for it. *Id.* DeBakey died eighteen months later at the age of ninety-nine. Lawrence K. Altman, *Michael DeBakey, 99, Rebuilder of Hearts, Dies*, N.Y. TIMES, July 13, 2008, at A1.

90. “Hypocrisy is the homage that vice pays to virtue.” Duc de La Rochefoucauld, *Reflections, or Sentences and Moral Maxims*, Maxim 218, in BARTLETT’S FAMILIAR QUOTATIONS 981 (10th ed. 1919).

91. See GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 21–28 (1978).

92. See *id.* at 140–41; Peter Singer, *Why We Must Ration Health Care: A Utilitarian Philosopher’s Argument for Placing a Dollar Value on Human Life*, N.Y. TIMES MAG., July 19, 2009, at 38.

that they think are not cost-effective,⁹³ and doctors employ formal and informal rationing methods, even as they may conceal this fact. (Battlefield medics, of course, have long used rules of thumb to make inescapable triage decisions about who can benefit most from the limited interventions that the desperate circumstances permit.)

Despite these examples, many wise people bristle at this sort of benefit-cost analysis or cost-effectiveness calculation,⁹⁴ and there is a large body of literature debating its merits in general, in particular forms, and as applied to specific interventions.⁹⁵ Yet most people are more likely to accept such policy analysis under two conditions. The first—that the resource shortage relative to demand and need are both clear and severe—is increasingly the case in health care. The bitter debate over President Obama’s health care proposals is only the most important example; few commentators deny the urgent need to control costs. The second condition is that people who want to opt out of this rationing and are able to bear the cost of private coverage can do so. While acknowledging the equality and fairness concerns raised by this condition, which gives an option to some people that is unavailable to poorer ones, there is no blinking the fact that this is a basic background condition of all of our social policies: the law allows wealthier Americans to purchase private insurance and make other private arrangements that avoid constraints to which those who must depend on public programs are subject. Egalitarian considerations aside, the vast majority of voters are much more likely to support measures designed to improve the well-being of the poor minority if those voters know that their own arrangements will not be limited or held hostage to the lesser options that government provides to the poor.

93. For a discussion on Medicare, see Scott Gottlieb, *How the U.S. Government Rations Health Care*, WALL ST. J., Sept. 30, 2009, at A23.

94. See, e.g., Irving Louis Horowitz, Letter to the Editor, *Why We Must Ration Health Care*, N.Y. TIMES MAG., Aug. 2, 2009, at 6 (criticizing Singer’s analysis and identifying the purpose of treatment as “to extend the care and life of people without regard to individual merits or even the collective costs to society”).

95. Compare RICHARD L. REVESZ & MICHAEL A. LIVERMORE, RETAKING RATIONALITY: HOW COST-BENEFIT ANALYSIS CAN BETTER PROTECT THE ENVIRONMENT AND OUR HEALTH (2008) (arguing that by reforming cost-benefit analysis, progressive groups can help enact strong environmental and public health regulations), with FRANK ACKERMAN & LISA HEINZERLING, PRICELESS: ON KNOWING THE PRICE OF EVERYTHING AND THE VALUE OF NOTHING (2005) (exposing the error of using cost-benefit analysis to decide whether human life and the environment are worth protecting).

In any event, few, if any, of our public or private health plans are explicit about rationing, especially by age. As noted earlier, they do exclude coverage for certain interventions and experimental procedures, but they generally do not impose any age-based or health status-based limits on costly treatments. Still, if insurers and policymakers are counting on physicians to be vigilant, cost-effective stewards of scarce health care resources, it is a vain hope: physicians are notoriously poor gatekeepers.⁹⁶ Powerful incentives—including ethical obligations, loyalty to their patients, a desire to gain a reputation for saving lives, knowledge that insurance will protect most of their patients from the costs, and possible personal financial interests—encourage them to make treatment and testing decisions as if those resources were essentially free and unlimited, rather than on cost-effectiveness grounds.

The heated controversy over the recent recommendations of the U.S. Preventive Services Task Force concerning age-based guidelines for mammography testing⁹⁷ perfectly illustrates this resistance to the clinical use of cost-effectiveness criteria. Anticipating, and reacting to, public and political charges that the guidelines will lead to rationing of mammography by government programs and private insurers and that this perception will in turn imperil the health care reform legislation pending in Congress, several revealing things happened. The Obama administration immediately gave assurances that neither mammography rationing nor other rationing of care would occur,⁹⁸ major private insurers indicated that they would not change their reimbursement rules,⁹⁹ and many private physicians insisted that they and their patients would not follow the new guidelines but would continue to do mammographic tests desired by their patients even if the Task Force—and even the physicians themselves—deemed them cost-ineffective.¹⁰⁰

96. See Letter to the Editor, *In H.M.O.'s, You Have to Know the Rules*, N.Y. TIMES, Jan. 18, 1995, at A20.

97. Gina Kolata, *Panel Urges Mammograms at 50, Not 40*, N.Y. TIMES, Nov. 16, 2009, at A1.

98. Kevin Sack & Gina Kolata, *Screening Policy Won't Change, U.S. Officials Say*, N.Y. TIMES, Nov. 18, 2009, at A1.

99. Natasha Singer & Reed Abelson, *Insurers Unlikely to Alter Policies in the Debate over Mammograms*, N.Y. TIMES, Nov. 18, 2009, at B1.

100. Pam Belluck, *Many Doctors to Stay the Course on Breast Exams for Now*, N.Y. TIMES, Nov. 18, 2009, at A1.

Even setting aside these social-psychological, political, and ethical obstacles to avoiding bad bets, there are daunting analytical difficulties in doing so. First, the analyst needs detailed information about the patient's medical condition to determine the potential benefits and costs of a particular treatment for that specific patient. Second, the analyst needs a broad database capable of revealing the frequency and magnitude of the bad bets problem in light of past outcomes and as applied to this category of patient, yet seldom are such fine-grained data on outcomes readily available.

Given these informational limitations, the best way to screen for bad bets at the individual level is to identify broad categories of potential recipients who probably would receive only modest benefits relative to other possible recipients and relative to the resources that they would use. Using age (or many other characteristics) as a basis for rationing may be politically dangerous (as in the case of mammography) or perhaps even illegal—even when doing so would predict relative cost-effectiveness. For example, federal civil rights law bars the use of age as a screening tool in federally assisted programs, subject to some broad exceptions.¹⁰¹ The United Kingdom used to ration kidney transplants using an age cutoff, but no longer does so.¹⁰² Indeed, the United Kingdom no longer uses age as an official consideration for any procedures. The much-debated Oregon Medicaid prioritization system did rank health interventions on cost-effectiveness grounds, essentially barring lower-ranked interventions.¹⁰³ Some of these rankings depended on the recipient's age, but seniors' opposition to this forced the George H. W. Bush administration to prohibit such uses of age—yet another sign of the political potency of the elderly.

Whether age is actually a good predictor of certain medical outcomes, moreover, may depend on which outcome measure one uses—for example, QALY gains as opposed to short-term survival rates. Alternatively, age may be a good marker of relative vulnerability to a disease, with the elderly often more vulnerable (as in the case of most cancers) and sometimes less vulnerable and thus less needful of

101. See Schuck, *supra* note 1, at 28.

102. BRITISH TRANSPLANTATION SOC'Y & THE RENAL ASS'N, UNITED KINGDOM GUIDELINES FOR LIVING DONOR KIDNEY TRANSPLANTATION 36 (2000).

103. OR. HEALTH SERVS. COMM'N, OFFICE FOR OR. HEALTH POLICY & RESEARCH, PRIORITIZATION OF HEALTH SERVICES 4 (2009).

treatment than others (as in the case of swine flu).¹⁰⁴ Age, of course, is a cruder predictor of the potential benefits of a medical intervention than one's specific medical condition would be, but it has the major advantages of being both easily measurable and objectively even-handed in the sense discussed earlier and below.

For health care, many people are bad bets simply because they are old or sick and thus have fewer QALYs left than younger people, including younger people with similar medical conditions. For this reason, rationing care simply on the basis of age may seem callous and invidiously discriminatory. But such rationing is prudent and fair so long as it is designed and implemented through a transparent democratic process that asks the right questions (including about the positive social effects of the elderly, such as their loving care of grandchildren) and that seeks the best answers to those questions, with seniors fully involved in the public debate. Policymakers may reject such rationing, of course, but we should be clear that, as Part VI will argue, no overriding notion of equity condemns it.

C. Recognizing Elderly Interests in Targeting Decisions

In the case of the elderly, we can be confident that any legislative or administrative effort to target resources on the basis of cost-effectiveness and QALY measures will satisfy these criteria of fair process, even where the targeting seems to favor younger over older people. (I say "seems" in order to underscore the difficulty of knowing in advance precisely how a policy will affect different groups, especially those that are internally heterogeneous.)

Several factors amply justify this confidence. First, as noted earlier, a policy that disadvantages the elderly is far less likely to be mean-spirited or animated by hostility, to represent an us-versus-them barrier, or to be otherwise invidious, than is a policy that disadvantages racial and other minorities whose characteristics or preferences are clearly distinct from those of the majority. After all, the elderly are not only our parents and grandparents; they are also *us*, as we will (all too soon) become. To harm the elderly, then, is in a real sense to risk harming ourselves at a future point in time that we all

104. See, e.g., Jennifer Steinhauer, *Anxious Crowds Meet Ad Hoc Swine Flu Police*, N.Y. TIMES, Oct. 28, 2009, at A1 (stating that in light of shortage of flu vaccine, elderly are urged not to get it because they are at lower risk than children).

earnestly hope to reach. In our more rational moments, at least, we recognize this fact. This is not to deny, of course, that decisions that implicate our identities across multiple time periods in the future (here, younger voters projecting their own frailty and vulnerability many years hence) are psychologically complex, epistemically uncertain, and thus anything but straightforward.¹⁰⁵

Second, the optimal conditions for making hard collective resource allocation choices that affect different groups differently arise precisely when voters know or suspect that they may themselves experience the full beneficial and adverse consequences of those choices. This foreknowledge encourages an uncommon self-discipline, highly salutary in a democracy like ours, that can encourage voters to make relatively wise, disinterested, egalitarian, and public-spirited decisions.

Third, as noted earlier, the elderly constitute a large, growing, and highly effective voting bloc fully capable of protecting its group interests, providing additional assurance that policies that steer away from elderly bad bets are unlikely to be adopted for hasty, ill-considered, or invidious reasons. If anything, the greater danger may be just the opposite: the elderly are so politically powerful that no policy that they think will adversely affect this is politically viable, regardless of how socially beneficial and fair the policy might seem to others.¹⁰⁶

Indeed, social policy today disproportionately favors the elderly over children. Social policy expert Julia Lynch notes that "U.S. social programs are more skewed toward the aged than in almost any other nation. The United States doles out nearly 40 times as much per senior citizen as per child and working-age adult."¹⁰⁷ A very recent report indicates that this imbalance favoring the elderly at the expense of children (and other groups) is actually growing; the share of federal

105. For example, we know little about the discount rates that younger people apply and the heuristics that affect their reasoning when they value future costs and benefits. The same is true of the discounting that seniors may do when assessing the tax burdens that their children's generation may have to bear.

106. This possibility depends, among other things, on how cohesive the senior electorate is. This may, in turn, depend on the precise shape of the demographic bulge, particularly whether some current and future seniors would actually benefit themselves if these social programs were reformed fiscally. If so, this might divide that electorate and facilitate reform. I am indebted to Daniel Markovits for this suggestion.

107. Jacob S. Hacker, *False Positive*, NEW REPUBLIC, Aug. 16, 2004, <http://www.tnr.com/article/False-positive-O>.

outlays for children was just under 10% in 2008 and is projected to decline to 8.3% in the next decade.¹⁰⁸ The political weight of the elderly makes them the most formidable status-quo force in American life today; this force will steadily grow in the future. In an environment demanding profound and unpopular changes, this deepening policy inertia is a recipe for disaster.

V. Hard Choices

The first point to be made about the hard choices that confront us is that these choices can be more or less well-informed. Although we do not know nearly all that we should want to know in order to target programmatic resources efficiently, existing studies of cost-effectiveness enable us to make better policy and allocation choices—better bets—than we have previously made.

In our book on targeting, for example, we present a table (4.1) that lists thirty discrete interventions—for infectious disease; for cancer; for neuropsychiatric and neurological, cardiovascular, respiratory, genitourinary, and musculoskeletal conditions; for congenital abnormalities; and for critical care.¹⁰⁹ Based on published, peer-reviewed cost-effectiveness studies, we list the cost per QALY for each intervention. It turns out that the cost-per-QALY differences among the interventions in each category are dramatic. For any reasonable value-of-life estimate—and the methodology for valuing life is now fairly well-developed—some of the interventions are clearly bad bets. Absent some other factor trumping cost-effectiveness, interventions that produce QALYs at relatively low cost should be funded before society moves up the ladder to more costly-per-QALY interventions for that condition. Indeed, if we are systemically rational and look *across* the illness categories and not just *within* them, we should follow the same targeting rule.

Three points deserve emphasis here. First, this approach is only as good as the underlying studies and the QALY estimates that they yield. This limitation, however, is equally true of *any* evidence-based decision technique.¹¹⁰ As it happens, the cost-effectiveness differences

108. JULIA B. ISAACS ET AL., KIDS' SHARE: AN ANALYSIS OF FEDERAL EXPENDITURES ON CHILDREN THROUGH 2008, at 31 (2009).

109. See SCHUCK & ZECKHAUSER, *supra* note 77, at 53 tbl.4-1.

110. Marc A. Rodwin, Commentary, *The Politics of Evidence-Based Medicine*, 26 J. HEALTH POL. POL'Y & L. 439, 442–43 (2001). The Obama administration's approach

across interventions and illness categories are sometimes large enough to swamp any reasonable disagreements about precisely how to value life for these purposes. Even where such differences might affect the ultimate choice, moreover, the analysis can keep us focused on the right question, which is the relative merits of the competing estimates.

Second, whatever the shortcomings of cost-effectiveness and QALY analyses in targeting scarce social resources—including their reliance on elusive information and emphasis on functionality—no one has yet come up with a better alternative. Critics of such analyses are generally unclear about their own methods, which customarily employ criteria that are more arbitrary and subjective, prevent rigorous analysis and criticism, or simply sweep the hard questions under the rug.¹¹¹

Third, and most relevant to my larger argument here, the cost-effectiveness differences among competing medical approaches are often highly sensitive to the patient's age. For example, tamoxifen treatment for primary prevention in women aged thirty-five at very high risk of breast cancer is \$45,000 per QALY, compared with \$89,000 for women aged fifty, and \$140,000 for women aged sixty.¹¹² The importance of age reflects both the inherent nature of the QALY measure (which, other things being equal, favors younger people), and the fact that, generally speaking, the success rate for most medical treatments declines with the patient's age. This means that the major gains that cost-effectiveness analysis can yield are likely to require targeting decisions that take the patient's age into account—not simply in the way that many physicians now informally consider age in deciding which interventions to recommend and undertake but in a more categorical fashion.

How categorical should such age-based targeting decisions be? A rule's optimal level of generality/specificity is always a complex, multidimensional question. This is especially true where (1) the rule's

to health care reform emphasizes cost control through evidence-based medicine, which is fraught with political risk. See Theodore Marmor et al., *The Obama Administration's Options for Health Care Cost Control: Hope Versus Reality*, 150 ANNALS OF INTERNAL MED. 485, 485–86 (2009).

111. For a critique of one such alternative, the so-called precautionary principle, see CASS R. SUNSTEIN, *LAWS OF FEAR: BEYOND THE PRECAUTIONARY PRINCIPLE* (2005). Two other approaches—ethical and rights-based theories—tend to operate at levels of generality that have little resolving power for difficult health care allocation choices.

112. SCHUCK & ZECKHAUSER, *supra* note 77, at 53 tbl.4-1.

applications may affect the quality of life and the risk of death; (2) any rule is likely to be underinclusive, overinclusive, or both; and (3) the rule's error costs may be high, may be heterogeneously distributed, and may be expensive to reduce. In such cases, pressure to grant exceptions for those excluded by the categorical rule will be great.¹¹³ In addition, we have seen that a strong ethos exists among physicians to do all they possibly can for all patients in their care, an ethos fortified by psychological, legal, insurance, and perhaps personal financial incentives. Finally, as the Oregon Medicaid experience shows, society, not just the treating physician, finds it hard to deny treatments for *A* while providing it to *B* simply because *A* is slightly older than *B* and so falls just over the bad bet line drawn by the age-based rule. Fear of slippery slopes is a common, sometimes justified objection to an age-based categorical rule.

But society should not rule out categorical rules altogether—it should not have a flat rule against flat rules—if, as I have argued, it has an overriding duty to target its scarce health care resources on those expected to benefit most from them, and if it wishes to avoid consuming too many of those resources in relatively costly case-by-case determinations of cost-effectiveness. Instead, it can try to palliate the crudeness of such rules at their edges. One approach is to adopt a flat age rule but allow those who can show that they are “type 1 errors” (i.e., the age rule excludes them but they are actually good bets¹¹⁴) to prove this and thus qualify for exceptions. A program might also allow those who are bad bets under the age rule access to the treatment only if they pay a higher fee; the fee could be calibrated to how far over the bad bet line they fall.

Significantly, this approach would reverse the logic of existing age discrimination statutes, which bar age discrimination categorically but then permit exceptions in which age is taken into account. In contrast, the proposed approach would permit flat rules that discriminate by age in the allocation of publicly subsidized health resources, while allowing individuals to show that they are cost-effective exceptions to that rule's crude generalization.¹¹⁵ I say “publicly subsidized” because

113. For a much fuller discussion of this problem, see *id.* at 99–128.

114. Type 2 errors—bad bets who nonetheless qualify for the treatment under the age rule—will consider themselves lucky to get the treatment and will not seek an exception.

115. Whether and how such exceptions congeal over time into a more general class constituting a rule or precedent for the future is an interesting, but for present

private insurers need no additional incentive to use cost-effective age targeting rules, especially if, as I have just proposed, the age discrimination laws do not prohibit them.

Having laid out the methodology for using better targeting to deal with hard choices, including rules based on age, I now turn to some important targets of opportunity in the area of medical care. (These focus, as the bank robber Willie Sutton did, on “where the money is.”) Two types of medical intervention—near the end of life and futile care—present the lowest-hanging fruit, although even here one must not underestimate the methodological, ethical, and political difficulties that each of them presents, difficulties all too evident in the current debates over health care reform.¹¹⁶

A. Near the End of Life

Critics often characterize as wasteful health expenditures made during the last month or year of life, reasoning that expenditures during this period accomplish little and must be bad bets. But it is only after the fact, of course, that we know a patient was in fact in the last period of his or her life. More important and perhaps surprising, Americans’ increased longevity per se is *not* a major driver of Medicare costs. Estimated lifetime expenditures under Medicare for people who die at the age of 101 and older are only 17% higher than for those who die at age 80.¹¹⁷ Indeed, the marginal costs associated with an additional year of life and annual payments both decrease as the age of death increases. This is good news—on average, people who live long lives are not bad bets for Medicare even in their advanced years. But from a broader policy and fiscal perspective, this is quite misleading in that it fails to reflect the high and rapidly rising costs of long-

purposes peripheral, question—one that I have analyzed in detail elsewhere. See generally Peter H. Schuck, *When the Exception Becomes the Rule: Regulatory Equity and the Formulation of Energy Policy Through an Exceptions Process*, 33 DUKE L.J. 163 (1984) (critiquing the problems which arise when equitable decisions in the area of energy regulation are viewed as precedent).

116. See generally Reed Abelson, *Months to Live: Weighing Medical Costs of End-of-Life Care*, N.Y. TIMES, Dec. 23, 2009, at A1; Roger S. Magnusson, *The Traditional Account of Ethics and Law at the End of Life—and Its Discontents*, 6 J. BIOETHICAL INQUIRY 308 (2009).

117. James Lubitz et al., *Longevity and Medicare Expenditures*, 332 NEW ENG. J. MED. 999, 1001 (1995).

term nursing home care for the elderly, most of which appear not on Medicare's budget but on Medicaid and private budgets.¹¹⁸

In terms of spending during the last year of life, the data also is counterintuitive: the older the individual is, the less Medicare spent in the last year of life, suggesting that it is cheaper for a person to wear out than to die an untimely death.¹¹⁹ Alternatively, society may be finding informal ways to spend much less money trying to save the very elderly, conceivably because society, the individual seniors, or their doctors or families think that greater investments would be bad bets—even though the patients themselves pay only a small share of the costs.

Leaving age aside, however, Medicare spends much more on those in the last year of life than it does on its other beneficiaries. A study using 1988 data found that although decedents in a given year made up only about 5% of the Medicare population over sixty-five, they made up 37% of the highest-cost 5%, and 47% of the highest-cost 1%.¹²⁰ (This is not an age phenomenon per se; as we just saw, annual Medicare expenditures tend to *decrease* with age, although their costs under Medicaid increase as they require long-term care covered by that program.) Overall, those in their last year of life use about 28% of the Medicare budget, roughly five to six times their proportional share. The last six months of life, moreover, account for about one-quarter of Medicare spending—a proportion that has not varied much in recent decades.¹²¹

The trend in such spending, moreover, is worrisome. Between 1985 and 1999, the rate of admission to intensive care units for decedents (i.e., those who die within six months after admission) jumped from 20.9% to 31%.¹²² In 1999, decedents accounted for 50% of feeding tube placements, 60% of intubations and tracheostomies, and 75% of

118. Brenda C. Spillman & James Lubitz, *The Effect of Longevity on Spending for Acute and Long-Term Care*, 342 NEW ENG. J. MED. 1409, 1414 (2000); see also THOMSON, *supra* note 5. Congress is considering a new long-term care program as part of the pending health care reform legislation. Anna Wilde Mathews, *Plan Creates New Program to Pay for Long-Term Care*, WALL ST. J., Nov. 4, 2009, at A6.

119. Spillman & Lubitz, *supra* note 118, at 1414.

120. See James D. Lubitz & Gerald F. Riley, *Trends in Medicare Payments in the Last Year of Life*, 328 NEW ENG. J. MED. 1092, 1095 (1993).

121. David Cutler & Patricia Keenan, *Health Care*, in UNDERSTANDING AMERICA: THE ANATOMY OF AN EXCEPTIONAL NATION 449, 454 (Peter H. Schuck & James Q. Wilson eds., 2008).

122. Amber E. Barnato et al., *Trends in Inpatient Treatment Intensity Among Medicare Beneficiaries at the End of Life*, 39 HEALTH SERV. RES. 363, 368 (2004).

cardiopulmonary resuscitations.¹²³ During that time, the share of those decedents who underwent an “intensive procedure during the final hospitalization” rose from 17.8% to 30.3%.¹²⁴ There is no reason to think that this upward trajectory has not continued in the last decade.

This would be fine if these individuals were receiving sufficient benefits from these expenditures, but their lives are not being extended significantly (by definition), and it is unlikely that their quality of life—on average, not in every case—is improved enough after these high costs are incurred to justify them. Indeed, many people die in hospitals when they would prefer to die at home, and most families experiencing a recent death wish that less care had been provided.¹²⁵ This does not *necessarily* mean that they were bad bets—some may have been good prospects for being restored to reasonably good health and significantly longer life—but it suggests that many, perhaps most, were indeed bad bets.

If we move to a much shorter period than one year before death, the bets are dramatically worse. More than half of the spending on decedents comes in the last sixty days of life, and more than 40% comes in their last thirty days.¹²⁶ (This implies that *one-eighth* of the overall Medicare budget is spent on individuals in the last *thirty* days of life.) Because death followed within a month, it seems quite unlikely that these individuals were good enough prospects for higher quality or more extended life at the time the expenditure decisions were made. Although treating physicians are keenly aware of the poor prognoses, the physicians’ complex incentives noted earlier—and the prospect that a few patients will indeed have better outcomes—push almost all of them toward making the bad bets.

With these facts in mind, consider the ethical case for limiting expenditures that, viewed *ex ante* by a medical decision maker, are likely to occur in the last few months of life of these bad bets. (The political case for doing so, of course, is quite another thing.¹²⁷) First, such

123. *Id.*

124. *Id.* at 369 tbl.2.

125. See Ian Yarett, *Beyond “Death Panels”: The Right Way to Die*, NEWSWEEK, Aug. 19, 2009, available at <http://www.newsweek.com/id/212693>.

126. SCHUCK & ZECKHAUSER, *supra* note 77, at 61.

127. See, e.g., Robert Pear & David M. Herszenhorn, *A Primer on the Details of Health Care Reform*, N.Y. TIMES, Aug. 10, 2009, at A8 (“Conservative critics say the legislation could limit end-of-life care and even encourage euthanasia. Moreover, some assert, it would require people to draw up plans saying how they want to die.”).

a limitation is even-handed; each of us will have a last few months of life.¹²⁸ Second, expenditures that are more than merely palliative probably do little to promote either the quantity or the quality of life, which is why many patients in this situation choose hospice care. Third, physicians are likely able to predict more accurately the imminent demise of patients who will in fact die within the next few months when the patients' lethal symptoms are probably more obvious than they are for patients who will in fact die more distantly. Finally, the resources saved by such a limitation can be used to help numerous other people (including bad draws) who are better bets than those who seem likely to die shortly. We may reasonably assume that any rational, disinterested person who understood these facts would want to minimize the wasteful treatment decisions that are now being made in the last thirty or sixty days of life even if she recognized that some of those decisions would extend life somewhat and, in a few cases, even significantly.¹²⁹

B. Futile Care

Now, consider another large category of bad bets—those who receive futile care, defined as nonpalliative interventions where the patient's *expected* health benefit is zero or so minimal as to not justify any significant cost. Clinicians, of course, often disagree about whether a treatment is futile for a particular patient in a specific situation and about whether treatment should be withheld or withdrawn. They disagree even more about quality-of-life predictions. Despite these disagreements, however, the futile care problem is significant enough to be worthy of more attention by policy analysts and providers. First, it wastes scarce program resources (by definition); the costs for Medicare patients who are predicted to die in the ICU are vastly disproportionate to their number.¹³⁰ Second, futile care (like some nonfutile but wasteful treatment, such as overuse of antibiotics and

128. As David Super notes, however, the young can hope that technological and other changes that occur before they reach that stage will improve their fates.

129. Rawlsian-type rulemaking about social justice, conducted behind his "veil of ignorance," would seem to endorse this view. JOHN RAWLS, *A THEORY OF JUSTICE* 118–22 (1971).

130. For data on this, see *supra* notes 77–78 and accompanying text; see also Jane E. Brody, *One Piece of Health Reform: Avoiding 'Bad' Deaths*, N.Y. TIMES, Aug. 18, 2009, at D7 (discussing how people vastly overestimate the chances of survival after resuscitation; on TV, more than 60% survive after CPR, while in real life only 5–10% of those over seventy survive hospital CPR).

unnecessary caesarean sections¹³¹) can actually make some patients worse off.¹³²

Recent studies indicate that hospice services, which seek to avoid futile and low-benefit care while improving the quality of the life that remains, can provide significant cost savings for patients dying of cancer (but apparently not for noncancer patients). Indeed, hospice care for cancer victims, greater use of advance directives, and less aggressive treatments for terminal patients would together save an estimated 6.1% of Medicare costs and 3.3% of total health care spending.¹³³

VI. Intergenerational Equity

From the technocratic and prescriptive, I now move to the ethical. Are the policy choices that I advocate just? What does one generation “owe” to other generations—in particular, those of its parents and of its children? This question, simple in appearance, raises a host of others that are anything but simple. What sorts of things might one generation “owe” another, and what are the source and nature of this obligation? Do intergenerational obligations go both ways? May the obligations of one generation be conditional on another generation behaving in certain ways? Are such obligations a matter of private choice or of public law and social policy? These are only a few of the ethical questions posed.¹³⁴

Some have claimed (rather implausibly, I think) that this intergenerational equity is a new topic of social debate. “[J]ustice over time,” Peter Laslett and James Fishkin assert, “did not exist as a subject of analysis or discussion, or even as a concept, before . . . the 1960s at the earliest.”¹³⁵ When it did emerge as an explicit concern, they

131. For a very recent example, see Joseph Pereira & Keith J. Winstein, *Benefit of Popular Spinal Surgery Is Questioned*, WALL ST. J., Aug. 6, 2009, at D1.

132. See, e.g., Brody, *supra* note 130 (“[C]ommon life-prolonging interventions can result in a host of debilitating or costly complications, like repeated infections, mental deterioration, serious drug reactions and persistent pain and discomfort. That doesn’t even include the distress experienced by family members tending to loved ones hooked up to myriad tubes and devices.”).

133. Ezekiel J. Emanuel & Linda L. Emanuel, *The Economics of Dying—The Illusion of Cost Savings at the End of Life*, 330 NEW ENG. J. MED. 540, 543 (1994).

134. There are also technical but consequential questions. For example, given constant demographic flux and continuity, how do we measure generations and identify the one to which we belong when they inevitably overlap?

135. Peter Laslett & James S. Fishkin, *Introduction: Processional Justice*, in JUSTICE BETWEEN AGE GROUPS AND GENERATIONS, *supra* note 53, at 14. They attribute

claim it emphasized the environmental and demographic claims that future generations can assert against current policymakers,¹³⁶ not on the resource distribution claims that an earlier generation (the elderly) can assert against those policymakers. Academic writing on intergenerational equity is the work of economists, moral philosophers, and lawyers; the economists seem preoccupied with the issue of the discount rate for valuing costs and benefits arising in the future,¹³⁷ while the philosophers and lawyers focus on the idea of an intergenerational contract.¹³⁸

The contract metaphor is obfuscatory and question-begging in this context. Clearly, no explicit contract between generations either does or could exist. Any obligation of the parental (i.e., working) generation to the grandparental (i.e., retired) generation, then, must rest on other grounds. It could be tactical on the part of the parents: they care for grandparents in order to set an example that will encourage the grandchildren to continue this norm once they themselves are parents and their own parents retire. But a self-interested tactic is not an obligation; it is quite the opposite. Alternatively, the obligation could be moral, in which case it must rest upon terms other than mere self-interest. What might these terms be? The most obvious sources of moral claims are religious precept, justified reliance on expectations and reciprocity, and simple gratitude.

A. Religion

Despite immense theological and other differences among the world's religions, the command to "honor thy father and thy mother" is perhaps universal.¹³⁹ Three aspects of this near-universal precept,

much, though not all, of this lack of systematic reflection on obligations to posterity to the dominance of Christian revelation. *Id.* at 15–18. Henry Sidgwick mentioned the subject but did not elaborate. *Id.* at 19.

136. *Id.* at 20.

137. See, e.g., Symposium, *Intergenerational Equity and Discounting*, 74 U. CHI. L. REV. 1, 2 (2007) ("The discounting effect is so powerful that it can drive the entire analysis of the problem."). But see Lawrence Summers & Richard Zeckhauser, *Policy-making for Posterity*, 37 J. RISK & UNCERTAINTY 115 (2008) (analyzing broader issues).

138. In Peter Laslett's version, it is a "tricontract." Laslett, *supra* note 53, at 25.

139. For a thought-provoking analysis of the different versions and interpretations of this commandment, with particular reference to responsibility for elders' long-term care, see Richard L. Kaplan, *Honoring Our Parents: Applying the Biblical Imperative in the Context of Long-Term Care*, 21 NOTRE DAME J. L. ETHICS & PUB. POL'Y 493 (2007).

however, are of interest here. First, it speaks of “honor,” not redistribution. Honoring parents may entail treating them with special respect, protecting them from destitution, indignity, and so forth, but beyond that it seems merely hortatory. Second, this duty of filial respect coexists with another, even more compelling, obligation to nurture and protect one’s children. Third, filial respect is a personal obligation, not a social one. Indeed, “socializing” this duty might, from a religious perspective, risk contradicting its core value.

B. Expectations and Reciprocity

For one to act in a way that engenders expectations by another may create a moral (and in some cases, a legal) obligation to meet those expectations. But this reliance is justified only if the expectations are reasonable. To avoid the problem of circularity, we must decide which expectations are in fact reasonable. Which reasonable expectations for public support, then, might a senior have? Peter Laslett, for whom the intergenerational relationship is best viewed as based on trust, not contract, analyzes seniors’ justified expectations in the welfare state context:

If we apply the trust notion to social goods originating in a parental generation . . . being transferred to a grandparental generation, the trustee is the State. . . . As time passes, individuals composing the cohorts that progress through the productive age-group make their contributions (that is, ordinarily pay their taxes) in the confident expectation—their just expectations under the trust—that those who come after will behave similarly. In due course those successors will expect their own successors to do the same. It is not a question in either instance of one party repaying another for benefits received earlier, which is why the transfer arrangement is more trustlike than contractlike. Nor is it a question of beneficiaries receiving a specified payment, never reducible, always increasable, at a particular time. This is because of the discretionary character of the trust, and because the trustees are obliged to provide for future demands due to anticipated demographic and economic¹⁴⁰ developments by accumulating a balancing fund as necessary.

In short, seniors’ expectations and reliance, to be reasonable, must be tailored to society’s other needs and its evolving constraints and realities. They cannot reasonably expect that even their legal entitlements to social provision will remain unchanged. For much the same rea-

140. Laslett, *supra* note 53, at 33.

son, seniors cannot expect an important, cognate social value—reciprocity—to carry the same welfare provision into the indefinite future. At most, reliance and reciprocity demand that significant reductions in that provision be foretold and phased in over time.

C. Gratitude

Perhaps the most powerful, morally based motive for this welfare provision is gratitude for the nurture and resources that current seniors provided to current workers when the latter were children.¹⁴¹ This sense of filial responsibility runs very deep, reflecting a mix of psychological, economic, and cultural factors.¹⁴² Again, however, the nature and precise scope of this moral duty, beyond that of basic protection and respect, are open questions. The duty seems too demanding—not to say socially dangerous—if defined to preclude today's voters from imposing any resource constraint that today's seniors did not impose on their parents (or their children) when today's seniors were worker-voters. My point is that although defining the duty this way is morally arguable, it is not morally compelling. The same is true of the claim that today's seniors created the very economic growth that underwrites today's Medicare and other social programs; it is morally relevant but not compelling.

Also relevant is the fact that each generation of American workers has been wealthier than the one before and that this pattern is likely to continue in the future. According to at least one analysis published in 2000, current workers will be wealthier than their parents even if they are taxed sufficiently to bring the Medicare and Social Security trust funds into long-term balance.¹⁴³ This possibility, however, does not resolve the moral dilemma; it only deepens it.

In thinking about these ethical questions, certain factual aspects of the current situation that were noted earlier stand out. Seniors today are living in the golden age of aging, receiving far greater levels of

141. The costs of parenting have become very high. See Rachel Emma Silverman, *Quarter-Million Dollar Baby: The High Costs of Raising Children*, WALL ST. J., Aug. 6, 2009, at D6. For an argument that each generation owes the next one the same per capita wealth that it inherited, see also BRUCE A. ACKERMAN, *SOCIAL JUSTICE IN THE LIBERAL STATE* 201–21 (1980) (discussing trusteeship).

142. For a recent analysis of the economic and social dimensions of family and nonfamily households, see ROBERT C. ELLICKSON, *THE HOUSEHOLD: INFORMAL ORDER AROUND THE HEARTH* 10 (2008).

143. Thompson, *supra* note 59, at 4.

social protection and resources than they provided to their own parents. In this sense, they are the beneficiaries of far more generosity than can be explained by the norms of gratitude, reliance, and reciprocity that underlie any obligation owed them by their working children. In addition, the rising dependency ratio imposes a burden of support on current and future workers far greater than that which the retiree generation bore toward their own parents. Most important, workers' obligations to their children exceed (by a large margin, I believe) any obligations to their retiree parents, and the conflict between these two obligations appears to be zero-sum¹⁴⁴ even though we may pretend otherwise.¹⁴⁵

My claim that current workers owe more to their children (and grandchildren) than to their parents rests on several factual premises. As just noted, their parents have already received far more resources than they (1) actually contributed to the retirement and Medicare systems that now support them, and (2) could reasonably have expected when they were young workers. Raising children today is much costlier than it was when the retirees were parents and indeed than ever before.¹⁴⁶ Coupled with longer life spans and periods of retirement, this means that the worker generation must simultaneously support their parents and their children—a double burden unprecedented in its magnitude.

In this sense, today's retirees have received a large windfall relative to their own parents and their children. In another sense, however, it is the retirees' children who may have received a windfall, as the intergenerational transfers go in both directions. Arguably, today's retirees paid out more to support their children (current workers) than the support they gain from their children's taxes for Medicare and Social Security.¹⁴⁷ This net transfer calculation, of course, is a complex one, sensitive to its assumptions.

144. I say "appears to be" in order to recognize the theoretical possibility that more resources for children would so increase their productivity as future workers that this marginal increase in economic growth could support even larger allocations to retirees without reducing the workers' wealth.

145. For an extended discussion of these issues, see THOMSON, *supra* note 5.

146. See Silverman, *supra* note 141.

147. Thompson, *supra* note 59, at 4 ("These estimates suggest that the present value of the initial transfer from the parents to the children in a typical middle-income household is likely to be comfortably above the present value of the transfers—in the form of future payroll taxes—from the children to the parents, even if payroll tax rates are increased to close the Social Security and Medicare financing

Perhaps most relevant to my claim from a moral point of view, retirees had alternatives—opportunities for self-help and self-support—that their grandchildren manifestly lack. Retirees (excepting those who were chronically unemployed or destitute during their working years through no fault of their own) could and should have used those years to save for their old age—as the vast majority of them did—by sacrificing some of their then-current wants. The fact that the welfare state thereafter augmented those savings to a largely unanticipated degree is simply icing on their cake. Their grandchildren will probably not have similar good fortune unless they manage to earn and save it themselves.

I hasten to add that I am under no illusion that less public spending on the elderly would necessarily mean more public spending directly on children rather than on, say, infrastructure, housing, defense, or tax reduction, which may benefit them (along with other citizens) but only indirectly. There is no assurance that Richard Lamm's wish to allocate to the education of youngsters resources that are now used turning eighty-year-olds into ninety-year-olds¹⁴⁸ will be gratified. Nor do I assume that any additional public spending on children would necessarily be cost-effective or that the government is the best allocator of resources for children. Indeed, the large increase in public spending on public elementary and secondary education since the 1970s, for example, appears to have had little positive effect on student achievement, graduation rates, or other measures of educational progress in our urban areas.¹⁴⁹ More generally, the correlation between spending per child and outcomes is weak; compared with other wealthy countries, the United States has one of the highest levels of such spending and among the worst outcomes.¹⁵⁰ Perhaps this lack of cost-effectiveness is because U.S. spending on older children is three times its spending on those of preschool age.¹⁵¹

The efficacy of better targeting of existing public resources, not to mention additional ones, ultimately depends not on technocratic

gaps. The transfer from the higher-income parents to their children seems to more closely approximate the transfer back in the form of future payroll taxes.”)

148. See *supra* text accompanying note 76.

149. See, e.g., ERIC A. HANUSHEK & ALFRED A. LINDSETH, *SCHOOLHOUSES, COURTHOUSES, AND STATEHOUSES: SOLVING THE FUNDING-ACHIEVEMENT PUZZLE IN AMERICA'S PUBLIC SCHOOLS* 52–58 (2009).

150. ORG. FOR ECON. CO-OPERATION & DEV., *DOING BETTER FOR CHILDREN* (2009), <http://www.oecd.org/dataoecd/21/9/43590390.pdf>.

151. *Id.*

rationality (although careful policy analysis is essential to progress), but on wise and courageous politicians and policymakers (hopefully guided by such analysis). Recognizing these uncertainties, it nevertheless seems likely that only a retargeting of some portion of those resources from the wants of the elderly to the needs of children can create the fiscal space within which those needs might be better met.¹⁵²

VII. Some Approaches to Policy Reform

My analysis has emphasized six broad, policy-relevant points. First, today's seniors in fact enjoy living conditions that in some respects exceed those of the average nonelderly American and that are also far better than they could reasonably have expected when they were young workers. Second, fiscal and demographic realities spell the imminent end of this golden age of aging. Third, seniors are more potent politically than any other single demographic group. Fourth, bad bets abound in our health care system.¹⁵³ Fifth, no compelling equitable principle can justify continuing these singular advantages at the expense of the younger generations, which have more pressing claims to social program resources now and which will likely find fewer of these resources available when they themselves become elderly. Sixth, the elderly account for a large fraction of these bad bets and of the costs that they generate, although no one knows the actual percentage. Although some elderly are bad bets because they are bad apples—for example, those who are frequently readmitted to hospitals due to substance abuse or other self-destructive behaviors¹⁵⁴—the vast majority of elderly bad bets are bad bets not through any fault of their own but simply because their age and physical condition make

152. See generally BRUCE ACKERMAN & ANNE ALSTOTT, *THE STAKEHOLDER SOCIETY* (1999) (describing one proposal in this spirit).

153. The fact that bad bets abound does not mean, of course, that our vast health care expenditures do not generate immense benefits or that these benefits in aggregate do not outweigh their aggregate costs. See DAVID CUTLER, *YOUR MONEY OR YOUR LIFE* (2004). It just means that many specific expenditures were bad bets.

154. Serial substance abusers account for a remarkably high share of total hospital costs, though most of them presumably are not elderly. See generally Christopher J. Zook & Francis D. Moore, *High-Cost Users of Medical Care*, 302 *NEW ENG. J. MED.* 996 (1980). Malcolm Gladwell describes fifteen chronically homeless inebriates and drug abusers who were treated in hospital emergency rooms a total of 417 times over eighteen months, running up medical bills averaging \$100,000 during this period. Malcolm Gladwell, *Million-Dollar Murray*, *NEW YORKER*, Feb. 13, 2006, at 96, 96–107.

many relatively expensive medical interventions not cost-effective for them.

If public programs must target health care spending to minimize bad bets, and if much of that targeting will necessarily aim at elderly bad bets, then the multi-billion-dollar question is this: which general policies (as distinct from patient-specific treatment decisions) can best promote cost-effectiveness with the least offense to our society's moral precepts? I shall briefly discuss five of them here.

A. Inform Patient Choice at the Time of Illness

Some patients, particularly elderly ones, may prefer to forego expensive treatment even if it has some low probability of benefitting them under certain conditions. We report on a recent example, surgery for lung volume reduction, in which many doctors and Medicare patients declined this procedure once they understood its high costs and low benefits. Currently only 1.6% of Medicare spending goes to hospice care.¹⁵⁵ This rate might be much higher, however, if doctors told their late-stage cancer patients the following:

Despite our treatments, your cancer has continued to progress. Though we could try treatment with an alternative regimen, I think the likelihood of a significant response is low. Further, there is a significant risk of making you ill or even hastening your death from complications of this aggressive drug combination. I am concerned about the quality of life in your remaining time. As an alternative, we could stop your treatments now, providing hospice care when needed. You would continue under my care to the end, and your pain would be controlled.

Where the patient is demented, informing family members that advanced dementia not only afflicts the mind but is a progressive, physical, terminal disease like advanced cancer, may cause family members to opt for less aggressive, costly treatment.¹⁵⁶

155. Medicare Payment Advisory Comm'n, *A Data Book: Healthcare Spending and the Medicare Program* 188 chart 12-10 (2008), http://www.medpac.gov/documents/Jun08DataBook_Entire_report.pdf.

156. Tara Parker-Pope, *Treating Dementia, but Overlooking Its Physical Toll*, N.Y. TIMES, Oct. 19, 2009, at D5. Studies indicate that increasing family members' knowledge affected treatment preferences, and that 71% of nursing home residents with advanced dementia died within six months of admission, yet only 11% were referred to hospice care. *Id.*

B. Encourage Pre-Illness Advance Directives

Asking patients to decide about bad bets when they are already seriously ill, however, will often be too late. In contrast, living wills, durable powers of attorney, and other forms of advance directives¹⁵⁷ encourage people to make informed choices earlier, at a time when they are more likely to make rational decisions and commit to abide by those decisions later on. (As with all precommitments, one can always argue that the person who made it earlier was a “different person” than the one who now faces death and that judgments about rationality should be “person”-specific in this sense.¹⁵⁸) Although a competent patient is always free to reverse the directive’s precommitments, which are usually broad, the fact that she has already thought hard about the trade-offs and knows that they were made at a time when her mind was free of the pressures and stresses of serious illness should make her more likely to adhere to them.

Although advance directives may not help much with treatments that generate some benefits on average but that are still not cost-effective, they can help to curtail bad bets and especially those likely to make the patient worse off in QALY terms. Relatively few Americans execute any kind of advance directive, and many of these directives are too vague to be truly useful.¹⁵⁹ Much more could be done to encourage such directives. Medicare and Medicaid could present a broad selection of optional directive forms as part of their initial enrollment processes, and private health plans could do so on a regular basis. Drawing on some states’ rules on cadaveric organ donations, the plans could present the most common form of advance directive as a default choice, with enrollees who prefer some other option having to act affirmatively to exercise it.¹⁶⁰ Employers, unions,

157. The legal term for such instruments is now “health care power of attorney.” UNIF. HEALTH CARE DECISIONS ACT (1993).

158. Many citizens, infuriated by a provision in a House health care reform bill that would pay doctors to counsel Medicare patients seeking advice on end-of-life issues such as living wills consider it a disguise for euthanasia. See, e.g., Naftali Bendavid, *Emanuel’s Brother Becomes a Target*, WALL ST. J., Aug. 13, 2009, at A4. This suspicion may in turn reflect this “different persons at different times” critique.

159. Brody, *supra* note 130, at D7. For an example of a much more specific directive, see Linda L. Emanuel & Ezekiel J. Emanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 J. AM. MED. ASS’N 3288 (1989).

160. On this general decision strategy, see RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

and public health groups could hold focus sessions on the subject. More radically, penalty defaults could be adopted to spur use of such directives, although imposing too many penalties would surely arouse a political reaction. Unfortunately, the recent political furor over demagogically denominated “death panels” in recent debates on health care reform may impede rational policymaking on advance directives.¹⁶¹

C. Guide Physician Decisions on Bad Bets

Medicare policymakers should set general default rules about who should receive which subsidized treatments based on large-population statistics. These rules will be highly controversial, of course, as they must rely on difficult statistical predictions about variables that have sometimes been used to discriminate invidiously, not rationally. Although physicians may reject these defaults when their superior patient-specific information indicates that their patient is a good bet for the treatment, opposition to rationing on the basis of these variables will persist.¹⁶²

With better cost-effectiveness information and greater acceptance of ethical justifications for prioritizing in response to it, physicians might be more inclined to initiate conversations of the kind that I just proposed. A more radical option, which may become more desirable as the research data improves, would be to expand the physician’s duty to obtain informed consent to include disclosing such cost-effectiveness information in bad bet situations. The courts should then support physicians against malpractice claims or a family’s demand for additional treatment that the physician denied because she deemed it a bad bet based on such data.

Numerous studies document that the same treatments are used with highly varying frequencies in different locales, and that when particular medical specialties prevail in a particular community, the specialists provide more—and more intensive—treatments than in other communities. This same pattern has been observed in hospitali-

161. See, e.g., Jim Rutenberg & Jackie Calmes, *False ‘Death Panel’ Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 13, 2009, at A1.

162. Judicial opposition to the federal sentencing guidelines a quarter-century after their adoption, while involving different variables and context, exemplifies the tension between general criteria and on-the-ground, case-specific decision making. *United States v. Booker*, 543 U.S. 220 (2005) (holding that the sentencing guidelines are advisory, not mandatory).

zation rates, lengths of stay, and other dimensions of health care. This suggests that specialists sometimes disserve their patients, delivering procedures that are not worthwhile to the patient (but are perhaps profitable to the physician). By educating physicians about bad bets and by linking insurance and provider reimbursement rates to cost-effective treatment decisions, incentives may become better aligned with efficiency.

D. Research on Cost-Effectiveness

Policymakers should subject most common medical interventions to much more extensive cost-effectiveness analysis in the service of evidence-based care—a goal now almost universally endorsed, too rarely implemented, and often jettisoned when the evidence is published and threatens existing expectations and practices.¹⁶³ All of the health reform plans pending in Congress would subsidize such research at a much higher level.¹⁶⁴ As this evidence accumulates over time, much innovation is likely as the kind of “value-based competition” analyzed by Michael Porter and Elizabeth Teisberg kicks in. Public and private insurance plans might state in advance that they will not pay for specified high-cost procedures of low or uncertain value, just as they often do for procedures regarded as still experimental. Assuming, as almost all health economists do, that the costs of employer-provided insurance come out of workers’ wages, such a policy would benefit all members of the public who ultimately pay the bill with their taxes, premiums, or wage reductions. In turn, employers, unions, and consumers choosing among competing health plans could take into account different insurers’ cost-effectiveness rules in coverage decisions, especially if public disclosure of such rules is mandated.

163. For a current example, see the earlier discussion of mammography testing. *See supra* text accompanying notes 98–104.

164. Whether this research should be supervised or regulated by a federal agency, as some have proposed, is an entirely separate question. For deep skepticism about such an agency, see Richard A. Epstein & David A. Hyman, *Controlling the Costs of Medical Care: A Dose of Deregulation* (Univ. Ill. Law & Econ. Research Paper No. LE08-023, 2009), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1158547.

E. Other Policy Changes

Certain other public policies could effectively limit bad bets in health care. As just noted, new reimbursement arrangements based on cost-effectiveness could dramatically change medical practice to encourage better bets. Medicare's Prospective Payment System, for example, caused a sharp decrease in the number of in-hospital deaths and a substantial rise in home care, office visits, and the use of outpatient equipment, apparently without stirring much patient protest, ethical controversy, or political backlash.¹⁶⁵

Another advance would be to deny reimbursement for diagnostic tests in situations where they can lead to expensive treatments but are likely to have little expected value based on age-based generalizations (although inevitably entailing occasional false positives) or on other generally valid predictive criteria. If, say, one percent of patients will substantially benefit from a test, they should be reimbursed for it—but only if they can be individually identified *ex ante* with high enough probability. This more cautious approach to testing is bolstered by recent research findings on the unfortunate propensity of prostate-specific antigen (PSA) screening to generate bad bet treatments for slow-growing prostate cancer where “watchful waiting” would be more individually and socially prudent.¹⁶⁶

VIII. Conclusion

In this golden age of aging, better bets can play a valuable role in improving social policy affecting the elderly, even as we recognize the values and common psychologies that encourage us to make bad bets. At some point, society must—in the name of compassion, justice, and fairness for others, including future seniors—say something like this:

The state must treat the elderly ill and other bad draws fairly before it classifies some of them as bad bets. But if the costs of bad bets are high enough, and if procedures sufficient to minimize errors and protect due process are in place, then we will make the hard decisions needed to avoid bad bets. We venerate our senior citizens and want to comfort them in their twilight years. At the

165. See Robert Steinbrook & Ronald J. Ostrow, *Medicare Study Finds Reforms' Impact Mixed, Improved In-Hospital Mortality Rates Offset by Hike in Release and Deaths of Unstable Patients*, L.A. TIMES, Apr. 30, 1989, available at http://articles.latimes.com/1989-04-30/news/mn-3136_1_elderly-patients-quality-of-hospital-care-death-rates.

166. Tara Parker-Pope, *Screen or Not? What Those Prostate Studies Mean*, N.Y. TIMES, Mar. 24, 2009, at D5.

same time, society must make hard choices; to fail to choose is to choose, but irrationally. Our seniors have had their chance to lead full, dignified lives and provide for their old age and infirmity while enjoying vast public subsidies during a golden age far beyond their reasonable expectations. Our top priority must be to assure that their politically weaker children, grandchildren, and great-grandchildren have that same chance.

I believe that we are now at that point.